

SI20255

KC\*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022709

STATE FILE NUMBER

26061

FILED JUL 7 1959

Registration District No.

Primary Registration District No.

Registration District No.

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>LEE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>DIXON</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VAH 915 N. GRAND</b>		Length of stay in lb <b>9 DAYS</b>	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>LYMAN S. BONNELL</b>			<b>JUNE 25 1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 28, 1895</b>		9. AGE (In years last birthday) <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSES AID</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	11. BIRTHPLACE (City and state or country) <b>GOLCONDA, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>SPENCE BONNELL</b>	13b. MOTHER'S MAIDEN NAME <b>MARTHA BARGER</b>	14. NAME OF HUSBAND OR WIFE <b>HE</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW-I</b>	16. SOCIAL SECURITY NO. <b>345-05-0149</b>	17. INFORMANT <b>VAH 915 N. GRAND AVE., ST. LOUIS, MO.</b>	Address
---	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRAPERITONEAL BLEEDING, SPLEEN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CARCINOMA OF KIDNEY, LEFT</b>	
	DUE TO (c) <b>CARCINOMATOSIS ABDOMEN, CHEST</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>180x</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	---	--	------------------------------	--------	-------

21. <input checked="" type="checkbox"/> attended the deceased from <b>JUNE 17, 1959</b> to <b>JUNE 25, 1959</b> and last saw <input checked="" type="checkbox"/> him alive on <b>JUNE 25, 1959</b> Death occurred at <b>4:25PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Murray Hett</i> <b>MURRAY HETT</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>6/26/59</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/26/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Equality, Ill</b>	23d. LOCATION (City, town, or county) <b>Equality, Ill</b>	(State)
---	-----------------------------	--	---	---------

24. FUNERAL DIRECTOR <b>Edward Fendler</b>	ADDRESS <b>5611 South Grand Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 26 59</b>	26. REGISTRAR'S SIGNATURE <i>Lead Smith</i> <b>M.R.</b>
---	--	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J. W. Humphrey* .....

Licensed Embalmer No. *772* .....

P. O. Address *H. P. ...* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.